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## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 9 FilmG216 5-29-57 et

04475

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Talbot</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Talbot</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rural Easton.</b>		LENGTH OF STAY (in this place) <b>5 yrs.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rural Easton.</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural give location)	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <b>Clarissa Tilghman Fleming Balch</b>				(Month) (Day) (Year) <b>April 5, 1957.</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>July 2, 1868</b>	9. AGE last birthday <b>88 89</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Fairfax County, Virginia.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S</b>	
13. FATHER'S NAME <b>Robert F. Fleming.</b>				14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Lee.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT & ADDRESS <b>Henry Herbert Balch, Easton Md.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <b>4520</b>				INTERVAL BETWEEN ONSET AND DEATH <b>?</b>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> et work <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> et work <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>2/8/57</b> , 19 <b>57</b> to <b>4/5/57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4/2/57</b> , 19 <b>57</b> , and that death occurred at <b>3:30</b> M., from the causes and on the date stated above.							
SIGNATURE <b>J. P. Cox</b>				ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>April 9, 57</b>		NAME OF CEMETERY OR CREMATORY <b>Holderness</b>		LOCATION (City, town, or county) (State) <b>Holderness. N. H.</b>	
24. REC'D BY REGISTRAR DATE <b>4/9/57</b>		REGISTRAR'S SIGNATURE <b>N. H. Newries</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Smith</b>		ADDRESS <b>Easton Md</b>	

# CERTIFICATE OF DEATH

Form 100-100

1. Usual Residence of Deceased

2. Date of Death

3. Place of Death

4. Cause of Death

5. Medical Attendant

6. Burial Place

7. Date of Burial

8. Signature of Registrar

9. Signature of Deceased

10. Signature of Next of Kin

11. Signature of Physician

12. Signature of Coroner

13. Signature of Jury

14. Signature of Witnesses

15. Signature of Registrar

16. Signature of Deceased

17. Signature of Next of Kin

18. Signature of Physician

19. Signature of Coroner

20. Signature of Jury

21. Signature of Witnesses

22. Signature of Registrar

23. Signature of Deceased

24. Signature of Next of Kin

25. Signature of Physician

26. Signature of Coroner

27. Signature of Jury

28. Signature of Witnesses

29. Signature of Registrar

30. Signature of Deceased

31. Signature of Next of Kin

32. Signature of Physician

33. Signature of Coroner

34. Signature of Jury

35. Signature of Witnesses

1. Usual Residence of Deceased

2. Date of Death

3. Place of Death

4. Cause of Death

5. Medical Attendant

6. Burial Place

7. Date of Burial

8. Signature of Registrar

9. Signature of Deceased

10. Signature of Next of Kin

11. Signature of Physician

12. Signature of Coroner

13. Signature of Jury

14. Signature of Witnesses

15. Signature of Registrar

16. Signature of Deceased

17. Signature of Next of Kin

18. Signature of Physician

19. Signature of Coroner

20. Signature of Jury

21. Signature of Witnesses

22. Signature of Registrar

23. Signature of Deceased

24. Signature of Next of Kin

25. Signature of Physician

26. Signature of Coroner

27. Signature of Jury

28. Signature of Witnesses

29. Signature of Registrar

30. Signature of Deceased

31. Signature of Next of Kin

32. Signature of Physician

33. Signature of Coroner

34. Signature of Jury

35. Signature of Witnesses

RECEIVED  
APR 15 1957  
BUREAU V. S.

SMOOTHMOUTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4476

## CERTIFICATE OF DEATH

04476

Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GRASONVILLE 17X22</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>R.F.D.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Walker Bouzma</u>		4. DATE OF DEATH Month Day Year <u>April 7 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 14, 1868</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>HARFORD CO., MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM HOLLOWAY</u>		14. MOTHER'S MAIDEN NAME <u>SARAH WILLS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. NELLIE B. MOUSLEY, GRASONVILLE MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Dis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>2 hr</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, _____, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rhane Wroth</u>		ADDRESS (Street, city or town, state) <u>St Michaels, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>R. LANE WROTH</u>		DATE SIGNED <u>2 April 57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>4/11/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ROCK RUN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HARFORD COUNTY MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hampton Gault</u>		ADDRESS <u>EASTON MD.</u>	
24a. REC'D BY REGISTRAR <u>DATE 4/11/57</u>		24b. REGISTRAR'S SIGNATURE <u>N.A. Newkirk</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 Film G214 4-18-57 et

CERTIFICATE OF DEATH

04477

Reg. Dist. No. 290

4477

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN TB <u>16 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>R</u> Last <u>Buck</u>				4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 14 1881</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u>14</u> Min. <u>57</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Victor B. Buck</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Robinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>1-34-123456789</u>		17. INFORMANT <u>Mrs. Bethune Buck (wife)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Esophageal Varices Hemorrhage</u> 581.0 DUE TO <u>cinchosis of liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hepatic coma - Liver Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>July</u> Day <u>4</u> Year <u>1957</u> Hour <u>3:20</u> a. m. <u>PM</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>St. Michaels, Md</u>	
20f. (City or town) <u>St. Michaels, Md</u>				20g. (County) <u>St. Michaels, Md</u>			
20h. (State) <u>Md</u>							
21. I certify that I attended the deceased from <u>July 4-8, 1957</u> to <u>July 4-8, 1957</u> , that I last saw the deceased alive on <u>July 4-8, 1957</u> , and that death occurred at <u>3:20 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomson</u>				DATE SIGNED <u>4-10-57</u>			
PHYSICIAN'S NAME (Type) <u>Thomson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4/11/57</u>		22b. DATE THEREOF <u>4/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Michaels, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman L. Marshall</u>				ADDRESS <u>St. Michaels, Md</u>		24a. REC'D BY REGISTRAR DATE <u>4/11/57</u>	
24b. REGISTRAR'S SIGNATURE <u>N. H. Neerius</u>							



CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. PLACE OF DEATH		14. DATE OF DEATH		15. TIME OF DEATH	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF NEXT OF KIN		23. SIGNATURE OF WITNESS		24. SIGNATURE OF PHYSICIAN		25. SIGNATURE OF REGISTRAR	
26. SIGNATURE OF DECEASED		27. SIGNATURE OF NEXT OF KIN		28. SIGNATURE OF WITNESS		29. SIGNATURE OF PHYSICIAN		30. SIGNATURE OF REGISTRAR	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF NEXT OF KIN		33. SIGNATURE OF WITNESS		34. SIGNATURE OF PHYSICIAN		35. SIGNATURE OF REGISTRAR	
36. SIGNATURE OF DECEASED		37. SIGNATURE OF NEXT OF KIN		38. SIGNATURE OF WITNESS		39. SIGNATURE OF PHYSICIAN		40. SIGNATURE OF REGISTRAR	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF NEXT OF KIN		43. SIGNATURE OF WITNESS		44. SIGNATURE OF PHYSICIAN		45. SIGNATURE OF REGISTRAR	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF NEXT OF KIN		48. SIGNATURE OF WITNESS		49. SIGNATURE OF PHYSICIAN		50. SIGNATURE OF REGISTRAR	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF NEXT OF KIN		53. SIGNATURE OF WITNESS		54. SIGNATURE OF PHYSICIAN		55. SIGNATURE OF REGISTRAR	
56. SIGNATURE OF DECEASED		57. SIGNATURE OF NEXT OF KIN		58. SIGNATURE OF WITNESS		59. SIGNATURE OF PHYSICIAN		60. SIGNATURE OF REGISTRAR	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF NEXT OF KIN		63. SIGNATURE OF WITNESS		64. SIGNATURE OF PHYSICIAN		65. SIGNATURE OF REGISTRAR	
66. SIGNATURE OF DECEASED		67. SIGNATURE OF NEXT OF KIN		68. SIGNATURE OF WITNESS		69. SIGNATURE OF PHYSICIAN		70. SIGNATURE OF REGISTRAR	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF NEXT OF KIN		73. SIGNATURE OF WITNESS		74. SIGNATURE OF PHYSICIAN		75. SIGNATURE OF REGISTRAR	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF NEXT OF KIN		78. SIGNATURE OF WITNESS		79. SIGNATURE OF PHYSICIAN		80. SIGNATURE OF REGISTRAR	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF NEXT OF KIN		83. SIGNATURE OF WITNESS		84. SIGNATURE OF PHYSICIAN		85. SIGNATURE OF REGISTRAR	
86. SIGNATURE OF DECEASED		87. SIGNATURE OF NEXT OF KIN		88. SIGNATURE OF WITNESS		89. SIGNATURE OF PHYSICIAN		90. SIGNATURE OF REGISTRAR	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF NEXT OF KIN		93. SIGNATURE OF WITNESS		94. SIGNATURE OF PHYSICIAN		95. SIGNATURE OF REGISTRAR	
96. SIGNATURE OF DECEASED		97. SIGNATURE OF NEXT OF KIN		98. SIGNATURE OF WITNESS		99. SIGNATURE OF PHYSICIAN		100. SIGNATURE OF REGISTRAR	

BUREAU V. 2

APR 15 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4478

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

04478

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock 09x02</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Cole</u> Last <u>Cole</u>				4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-20-57</u>	
9. AGE (In years last birthday) yrs. <u>12</u>		IF UNDER 1 YEAR Months <u>12</u> Days <u>10</u>		IF UNDER 24 HRS. Hours <u>12</u> Min. <u>10</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Maurice E. Cole</u>				14. MOTHER'S MAIDEN NAME <u>Ella Mae Harding</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mr. Maurice E. Cole (father)</u>				Address <u>Hurlock, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Congenital anomalies</u> <u>759.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acromid</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> P. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>219 S Washington St 2147</u> DATE SIGNED <u>4/22/57</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				LOCATION (City, town, or county) <u>Easton 16, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-22-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>		22d. LOCATION (City, town, or county) <u>Hurlock Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth S. Maloney</u>				ADDRESS <u>E. N. Market</u>		24a. REC'D BY REGISTRAR <u>N. H. Newlin</u> DATE <u>4/22/57</u>	

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CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JUDGE		17. SIGNATURE OF CLERK		18. SIGNATURE OF SHERIFF	
19. SIGNATURE OF DEPUTY SHERIFF		20. SIGNATURE OF CONSTABLE		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

RECEIVED  
APR 29 1957  
BUREAU V. 3



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar by the funeral director, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4502

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>		c. LENGTH OF STAY IN 1b <u>3 wks</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St Michaels</u>		d. STREET ADDRESS <u>Academy</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kiss Vista Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Smith</u> Last <u>Bishop Cottman</u>		4. DATE OF DEATH Month <u>4</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/1/1871</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Cottman</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Ballard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr. Harry B. Smith, Dorchester, Md</u>	
17. INFORMANT <u>Mr. Harry B. Smith, Dorchester, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic clonic heart disease</u> DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, chronic (?)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>25 Feb</u> , 19 <u>57</u> , to <u>27 Mar</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>27 Mar</u> , 19 <u>57</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thorston Harrison</u> M.D.		DATE SIGNED <u>15 Apr 57</u>	
PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/15/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth S. Talbotby</u> ADDRESS <u>C. N. Market St</u>		24a. REC'D BY REGISTRAR <u>Mr. B. B. Smith</u>	
24b. REGISTRAR'S SIGNATURE <u>Mr. B. B. Smith</u>		DATE <u>APR 18 1957</u>	

CERTIFICATE OF DEATH

202

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		COUNTY [Faint text]	
TIME OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		SEX [Faint text]	
OCCUPATION [Faint text]		EDUCATION [Faint text]		RELIGION [Faint text]	
MARITAL STATUS [Faint text]		PREVIOUS MARRIAGES [Faint text]		PREVIOUS DEATHS [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CORONER [Faint text]		SIGNATURE OF JURY [Faint text]		SIGNATURE OF JUDGE [Faint text]	

BUREAU V. S.

APR 18 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

05574

Reg. Dist. No. 290

4479

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock 09x02</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>			d. STREET ADDRESS <u>S. Washington Street</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Cleckend Eugene Coulbourn</u>			4. DATE OF DEATH Month Day Year <u>4 30 1957</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23 1884</u>		9. AGE (In years last birthday) yrs. <u>72</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Mr Eugene Coulbourn</u>			14. MOTHER'S MAIDEN NAME <u>Winda Thomas</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>7-10-10000</u>		
17. INFORMANT <u>Miss Elsie Coulbourn</u>			Address <u>Hurlock, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiac disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>chronic retention due to B.P.H.</u>					
INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>4/13/57</u> 19 <u>57</u> to <u>4/30/57</u> that I last saw the deceased alive on <u>4/29/57</u> 19 <u>57</u> , and that death occurred at <u>4:50 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Easton Md</u>					
ACTUAL SIGNATURE <u>P. E. Cox</u>			M.D. <u>Easton Md</u>		
PHYSICIAN'S NAME (Type) <u>P. E. Cox</u>			<u>EASTON, MARYLAND</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>	
22d. LOCATION (City, town, or county) (State) <u>Hurlock Md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frumpton</u>		ADDRESS <u>San Federalburg Md</u>	
24a. REC'D BY REGISTRAR <u>5/2/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Neeris</u>			

# CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. MARITAL STATUS [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. MEDICAL HISTORY [Faint text]</p>		<p>10. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>11. SIGNATURE OF DECEASED [Faint text]</p>		<p>12. SIGNATURE OF WITNESSES [Faint text]</p>	
<p>13. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>14. SIGNATURE OF CLERK [Faint text]</p>	
<p>15. SIGNATURE OF JUDGE [Faint text]</p>		<p>16. SIGNATURE OF SHERIFF [Faint text]</p>	
<p>17. SIGNATURE OF DISTRICT ATTORNEY [Faint text]</p>		<p>18. SIGNATURE OF COUNTY CLERK [Faint text]</p>	
<p>19. SIGNATURE OF TOWNSHIP CLERK [Faint text]</p>		<p>20. SIGNATURE OF VILLAGE CLERK [Faint text]</p>	
<p>21. SIGNATURE OF CITY CLERK [Faint text]</p>		<p>22. SIGNATURE OF STATE CLERK [Faint text]</p>	
<p>23. SIGNATURE OF NATIONAL CLERK [Faint text]</p>		<p>24. SIGNATURE OF INTERNATIONAL CLERK [Faint text]</p>	

BUREAU V. S.

MAY 8 1957

RECEIVED

4543

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton Rural</u>				c. LENGTH OF STAY IN 1b <u>all life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Helan</u> Middle <u>Smith</u> Last <u>Daffin</u>				4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 2 1889</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>6</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Tunis Mills, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James P. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Anna Lavery Daffin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-18-4915</u>		17. INFORMANT Address <u>William Carl Daffin Easton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1946</u> , to <u>4/8/57</u> , 19 <u>57</u> that I last saw the deceased alive on <u>4/8/57</u> , 19 <u>57</u> , and that death occurred at <u>11-P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton Md</u> DATE SIGNED <u></u>							
ACTUAL SIGNATURE <u>J. B. Williams</u> M.D. <u>Easton Md</u>				PHYSICIAN'S NAME (Type) <u></u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Apr. 11, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Williams</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR <u>4/11/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Herries</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

BUREAU V. 2

APR 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G215 5-10-57 et

## CERTIFICATE OF DEATH

04482

Reg. Dist. No. 290

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Talbot</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>37 Pleasant St.</u>				d. STREET ADDRESS <u>1 37 Pleasant St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Addie</u> Middle <u>S</u> Last <u>Dobson</u>				<b>4. DATE OF DEATH</b> Month <u>4</u> Day <u>17</u> Year <u>1957</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>Cal</u>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Dec 26, 1902</u>	<b>9. AGE</b> (In years last birthday) <u>54 3/5</u> yrs.	<b>IF UNDER 1 YEAR</b> Months _____ Days _____ Hours _____ Min. _____	<b>IF UNDER 24 HRS.</b> Months _____ Days _____ Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Canning</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Factory</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>John Seth</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Skinner</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>215-16-8223</u>	<b>17. INFORMANT</b> <u>John E. Davidson, Easton, Md</u>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma Stomach</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>? 3 months</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)				
<b>21. I certify that I attended the deceased from</b> <u>3/23, 1937</u> <b>to</b> <u>3/27, 1957</u> <b>that I last saw the deceased alive on</b> <u>3/27, 1957</u> <b>and that death occurred at</b> _____ <b>M, from the causes and on the date stated above.</b> ADDRESS (Street, city or town, state) DATE SIGNED							
<b>ACTUAL SIGNATURE</b> <u>J. W. P. Garne</u> M.D.							
<b>PHYSICIAN'S NAME (Type)</b>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>22b. DATE THEREOF</b> <u>4/20/57</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Richards Cem.</u>	<b>22d. LOCATION</b> (City, town, or county) (State) <u>Easton Md.</u>				
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>James B. Odell, Easton, Md.</u>			<b>24a. REC'D BY REGISTRAR</b> DATE <u>APR 29 1957</u>	<b>24b. REGISTRAR'S SIGNATURE</b> <u>N. A. Thomas</u>			

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar	
James E. ...		45		Male		White		1912		1957		Home		Heart Disease		Natural		[Signature]		[Signature]	
Occupation		Education		Marital Status		Previous Illnesses		Last Medical Examination		Time of Death		Time of Discovery		Time of Reporting		Time of Burial		Time of Interment		Time of Cremation	
Teacher		High School		Married		None		1956		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM		10:00 AM	
Place of Birth		Place of Residence		Place of Death		Place of Burial		Place of Cremation		Place of Interment		Place of Exhumation		Place of Reinterment		Place of Reinterment		Place of Reinterment		Place of Reinterment	
Maryland		Baltimore		Baltimore		Baltimore		Baltimore		Baltimore		Baltimore		Baltimore		Baltimore		Baltimore		Baltimore	

**RECEIVED**  
 BUREAU V. 3  
 1957 09 29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4481

## CERTIFICATE OF DEATH

04483

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>126 W. Dover St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>ALVIN</b> Last <b>DULIN</b>				4. DATE OF DEATH <b>April 13, 1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 1, 1898</b>	
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months <b>13</b> Days <b>13</b> Hours <b>19</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>Thomas H. Dulin</b>				14. MOTHER'S MAIDEN NAME <b>Anna M. Ferguson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-01-8631</b>		17. INFORMANT <b>Mr. Wendell Dulin</b> Address <b>Easton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>163X</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1956</b> , to <b>4/13/57</b> , that I last saw the deceased alive on <b>4/12/57</b> , and that death occurred at <b>9:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>P. Evans Cox</b> M.D.				PHYSICIAN'S NAME (Type) <b>Dr. P. Evans Cox</b> <b>Easton, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 15, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Easton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newnam &amp; Son</b>				ADDRESS <b>Easton, Md.</b>		24a. REC'D BY REGISTRAR <b>7/15/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>N. H. Newnam</b>			

BUREAU V. S.

APR 23 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Item 9 Film G215 4-17-57 et  
**CERTIFICATE OF DEATH**

04484

Reg. Dist. No.

291

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Queen Anne</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Whittman</b>				c. LENGTH OF STAY IN 1b <b>3 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chester 20x01</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Susie</b> Middle <b>A.</b> Last <b>Dunn</b>				4. DATE OF DEATH Month <b>4</b> Day <b>11</b> Year <b>19 57</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>82 (?) yrs.</b>		9. AGE (In years lost birthday) <b>82 (?) yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel R. Dunn</b>				14. MOTHER'S MAIDEN NAME <b>Susie A. Bailey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Oscar Dunn</b>		Address <b>Chester, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Spontaneous pneumonia</b> <b>480x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction</b> DUE TO (c) <b>influenza &amp; sinusitis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days</b> <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1953</b> to <b>April 1957</b> that I last saw the deceased alive on <b>April 11 1957</b> , and that death occurred at <b>4 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>GUY M REESER</b> M.D. <b>TILGHMAN</b> PHYSICIAN'S NAME (Type) <b>GUY M REESER SR. TILGHMAN MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-16-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Chester, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James D. Easton, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 22 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Thos. A. R. Smith</b>	

BUREAU A. S.

APR 22 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04485

4482

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>		d. STREET ADDRESS <u>5. WASHINGTON, Md</u>	
3. NAME OF DECEASED (Type or print) First <u>NORMAN</u> Middle <u>L</u> Last <u>GAMBRILL</u>		4. DATE OF DEATH Month <u>4</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 13 1887</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William A. Gambrell</u>		14. MOTHER'S MAIDEN NAME <u>Annie Virginia Willis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Nellie M. Gambrell, same - wife</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Laennec's Cirrhosis, Far Advanced</u> DUE TO (c) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331x</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/20</u> , 19 <u>57</u> , to <u>7/29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/29</u> , 19 <u>57</u> , and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. Krech, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Easton</u> DATE SIGNED <u>7/30/57</u>	
PHYSICIAN'S NAME (Type) <u>S. Krech, Jr.</u>		<u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-2-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. F. Fenton</u> ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>5/1/57</u>	
24b. REGISTRAR'S SIGNATURE <u>N. H. Newlin</u>			

CERTIFICATE OF DEATH

PLACE OF DEATH		MAY 8 1957	
DATE OF DEATH		MAY 8 1957	
TIME OF DEATH		MAY 8 1957	
AGE		MAY 8 1957	
SEX		MAY 8 1957	
RACE		MAY 8 1957	
EDUCATION		MAY 8 1957	
OCCUPATION		MAY 8 1957	
MANNER OF DEATH		MAY 8 1957	
CAUSE OF DEATH		MAY 8 1957	
DISEASE		MAY 8 1957	
SYMPTOMS		MAY 8 1957	
TREATMENT		MAY 8 1957	
HISTORY		MAY 8 1957	
FAMILY HISTORY		MAY 8 1957	
SOCIAL HISTORY		MAY 8 1957	
PSYCHOLOGICAL HISTORY		MAY 8 1957	
PATHOLOGICAL FINDINGS		MAY 8 1957	
LABORATORY FINDINGS		MAY 8 1957	
X-RAY FINDINGS		MAY 8 1957	
AUTOPSY FINDINGS		MAY 8 1957	
OTHER FINDINGS		MAY 8 1957	
SIGNATURE OF PHYSICIAN		MAY 8 1957	
SIGNATURE OF REGISTRAR		MAY 8 1957	
SIGNATURE OF WITNESS		MAY 8 1957	
SIGNATURE OF CORONER		MAY 8 1957	
SIGNATURE OF JURY		MAY 8 1957	
SIGNATURE OF JUDGE		MAY 8 1957	
SIGNATURE OF CLERK		MAY 8 1957	
SIGNATURE OF NURSE		MAY 8 1957	
SIGNATURE OF CHAPLAIN		MAY 8 1957	
SIGNATURE OF MINISTER		MAY 8 1957	
SIGNATURE OF RABBI		MAY 8 1957	
SIGNATURE OF OTHER		MAY 8 1957	

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MAY 8 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4505

## CERTIFICATE OF DEATH

Reg. Dist. No. 04486 290

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Cordova</b>				c. LENGTH OF STAY IN 1b <b>30 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>Rural Cordova</b>			
3. NAME OF DECEASED (Type or print) <b>IDA F. GARDNER</b>				4. DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 14, 1868</b>		9. AGE (In years last birthday) <b>89</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				13. FATHER'S NAME <b>Leonard Swartz</b>			
14. MOTHER'S MAIDEN NAME <b>Mary Rife</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Julian T. Bromwell</b> Address <b>Cordova, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO <b>450.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>JUNE</b> , 19 <b>54</b> , to <b>APRIL 27</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>APRIL 27</b> , 19 <b>57</b> , and that death occurred at <b>7:05 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Donald F. Bartley</b>				ADDRESS (Street, city or town, state) <b>9 N. Hanson St. Easton, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Donald F. Bartley</b>				DATE SIGNED <b>4-29-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 30, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Easton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newnam &amp; Son</b>				ADDRESS <b>Easton, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>4/30/57</b>	
24b. REGISTRAR'S SIGNATURE <b>N.H. Newnam</b>							



CERTIFICATE OF DEATH

2215

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John J. Jones		Male		35 years		April 14, 1957		New York City	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Occupation	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Teacher	
Date of Birth		Place of Birth		Date of Admission to Hospital		Date of Discharge from Hospital		Date of Burial	
April 14, 1957		New York City		April 14, 1957		April 14, 1957		April 14, 1957	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Death		Place of Death		Date of Burial		Place of Burial		Date of Interment	
April 14, 1957		New York City		April 14, 1957		New York City		April 14, 1957	
Name of Burial Officer		Name of Registrar		Name of Coroner		Name of Medical Examiner		Name of Physician	
[Name]		[Name]		[Name]		[Name]		[Name]	
Signature of Burial Officer		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Physician	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Burial		Place of Burial		Date of Interment		Place of Interment		Date of Burial	
April 14, 1957		New York City		April 14, 1957		New York City		April 14, 1957	

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MAY 2 1957  
BUREAU V.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04487

4483

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>18 da.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Garrison</u> Last <u>Garrison</u>				4. DATE OF DEATH Month <u>4</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 18, 1881</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Frank Garrison</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Hoover</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>My alex Thomas (friend)</u> Address <u>Seasonsville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured hip</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>  </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3/22</u> , 19 <u>57</u> , to <u>4/9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/9/57</u> , 19 <u>  </u> , and that death occurred at <u>9 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P.S. Cox</u>				DATE SIGNED <u>Easton, Ind</u>			
PHYSICIAN'S NAME (Type) <u>P.S. COX</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Seasonsville</u>		22d. LOCATION (City, town, or county) (State) <u>Seasonsville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgate L. Lane</u>				ADDRESS <u>Church Hill Md</u>		24a. REC'D BY REGISTRAR <u>DATE 4/12/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>N.H. Neerinx</u>			

BUREAU V. S.

APR 23 1957

RECEIVED

4484

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Calbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greensboro 05x02</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Gleaves</u> Last <u></u>				4. DATE OF DEATH April <u>11</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 16, 1890</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Gleaves</u>				14. MOTHER'S MAIDEN NAME <u>Mary Laws</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Hester Gleaves (Same)</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Misadventure under Anesthesia</u> <u>570.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>dissection + rupture of abdominal aortic aneurysm</u> DUE TO (c) <u>thrombosis of sigmoid</u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>954X</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Louis S. Nelly DME</u> M.D.				ADDRESS (Street, city or town, state) <u></u> DATE SIGNED <u>4-17-57</u>			
PHYSICIAN'S NAME (Type) <u>Louis S. Nelly</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shenton</u>		22d. LOCATION (City, town, or county) (State) <u>Shenton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulais</u> ADDRESS <u>Greensboro, Md.</u>				24a. REC'D. BY REGISTRAR <u></u> DATE <u>4/14/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. A. Newrix</u>	

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. COUNTY	
3. STREET ADDRESS		4. CITY	
5. STATE		6. ZIP CODE	
7. DECEASED'S SEX		8. DECEASED'S AGE	
9. DECEASED'S RACE		10. DECEASED'S RELIGION	
11. DECEASED'S OCCUPATION		12. DECEASED'S MARITAL STATUS	
13. DECEASED'S BIRTH DATE		14. DECEASED'S BIRTH PLACE	
15. DECEASED'S BIRTH COUNTRY		16. DECEASED'S BIRTH STATE	
17. DECEASED'S BIRTH CITY		18. DECEASED'S BIRTH COUNTY	
19. DECEASED'S BIRTH STATE		20. DECEASED'S BIRTH COUNTRY	
21. DECEASED'S BIRTH DATE		22. DECEASED'S BIRTH PLACE	
23. DECEASED'S BIRTH COUNTRY		24. DECEASED'S BIRTH STATE	
25. DECEASED'S BIRTH CITY		26. DECEASED'S BIRTH COUNTY	
27. DECEASED'S BIRTH STATE		28. DECEASED'S BIRTH COUNTRY	
29. DECEASED'S BIRTH DATE		30. DECEASED'S BIRTH PLACE	
31. DECEASED'S BIRTH COUNTRY		32. DECEASED'S BIRTH STATE	
33. DECEASED'S BIRTH CITY		34. DECEASED'S BIRTH COUNTY	
35. DECEASED'S BIRTH STATE		36. DECEASED'S BIRTH COUNTRY	
37. DECEASED'S BIRTH DATE		38. DECEASED'S BIRTH PLACE	
39. DECEASED'S BIRTH COUNTRY		40. DECEASED'S BIRTH STATE	
41. DECEASED'S BIRTH CITY		42. DECEASED'S BIRTH COUNTY	
43. DECEASED'S BIRTH STATE		44. DECEASED'S BIRTH COUNTRY	
45. DECEASED'S BIRTH DATE		46. DECEASED'S BIRTH PLACE	
47. DECEASED'S BIRTH COUNTRY		48. DECEASED'S BIRTH STATE	
49. DECEASED'S BIRTH CITY		50. DECEASED'S BIRTH COUNTY	
51. DECEASED'S BIRTH STATE		52. DECEASED'S BIRTH COUNTRY	
53. DECEASED'S BIRTH DATE		54. DECEASED'S BIRTH PLACE	
55. DECEASED'S BIRTH COUNTRY		56. DECEASED'S BIRTH STATE	
57. DECEASED'S BIRTH CITY		58. DECEASED'S BIRTH COUNTY	
59. DECEASED'S BIRTH STATE		60. DECEASED'S BIRTH COUNTRY	
61. DECEASED'S BIRTH DATE		62. DECEASED'S BIRTH PLACE	
63. DECEASED'S BIRTH COUNTRY		64. DECEASED'S BIRTH STATE	
65. DECEASED'S BIRTH CITY		66. DECEASED'S BIRTH COUNTY	
67. DECEASED'S BIRTH STATE		68. DECEASED'S BIRTH COUNTRY	
69. DECEASED'S BIRTH DATE		70. DECEASED'S BIRTH PLACE	
71. DECEASED'S BIRTH COUNTRY		72. DECEASED'S BIRTH STATE	
73. DECEASED'S BIRTH CITY		74. DECEASED'S BIRTH COUNTY	
75. DECEASED'S BIRTH STATE		76. DECEASED'S BIRTH COUNTRY	
77. DECEASED'S BIRTH DATE		78. DECEASED'S BIRTH PLACE	
79. DECEASED'S BIRTH COUNTRY		80. DECEASED'S BIRTH STATE	
81. DECEASED'S BIRTH CITY		82. DECEASED'S BIRTH COUNTY	
83. DECEASED'S BIRTH STATE		84. DECEASED'S BIRTH COUNTRY	
85. DECEASED'S BIRTH DATE		86. DECEASED'S BIRTH PLACE	
87. DECEASED'S BIRTH COUNTRY		88. DECEASED'S BIRTH STATE	
89. DECEASED'S BIRTH CITY		90. DECEASED'S BIRTH COUNTY	
91. DECEASED'S BIRTH STATE		92. DECEASED'S BIRTH COUNTRY	
93. DECEASED'S BIRTH DATE		94. DECEASED'S BIRTH PLACE	
95. DECEASED'S BIRTH COUNTRY		96. DECEASED'S BIRTH STATE	
97. DECEASED'S BIRTH CITY		98. DECEASED'S BIRTH COUNTY	
99. DECEASED'S BIRTH STATE		100. DECEASED'S BIRTH COUNTRY	

BUREAU V. S.

APR 23 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5, 6, 7 Film G215 5-10-57 et

4485

CERTIFICATE OF DEATH

Reg. Dist. No.

04489

290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 EASTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>316 talbot st</u>				d. STREET ADDRESS <u>316 talbot st</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Green</u> Last <u>Green</u>				4. DATE OF DEATH Month <u>4</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/25/1897</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Sewell</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-22-4872</u>		17. INFORMANT <u>Norman Miller, St Michael's</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>High Blood Pressure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u> <u>yes</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>57</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1-1</u> , 19 <u>54</u> , to <u>4-21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-20</u> , 19 <u>57</u> , and that death occurred at <u>4 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. H. Buell</u> M.D.				ADDRESS (Street, city or town, state) <u>Easton Md</u> DATE SIGNED <u>APR 29 1957</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/26/57</u>		<u>Richards Cem</u>		<u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Schied</u>				ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 29 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>N. H. Newing</u>			

CERTIFICATE OF DEATH

Form with fields for Name, Age, Sex, Race, Date of Birth, Date of Death, Cause of Death, and other medical details. Includes handwritten entries such as "M. J. Smith" and "1991".

BUREAU Y. 2

APR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04490

4486

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY <b>Talbot</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>				c. LENGTH OF STAY IN 1b <b>16 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalburg 05x02</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Easton Memorial Hospital</b>				d. STREET ADDRESS <b>Federalburg 05x02</b>			
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>G.</b> Last <b>Herr</b>				4. DATE OF DEATH Month <b>4</b> Day <b>18</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 3 1921</b>		9. AGE (In years last birthday) <b>35</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Michigan Penna</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Lloyd Herr</b>			
14. MOTHER'S MAIDEN NAME <b>Bessie Rogers</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes World War II</b>			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Margaret Herr, wife - Federalburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>463X Pulmonary embolism</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Deep Throat Infection, left leg</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>002X Pulmonary Tuberculosis</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. 11. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>4/3</b> , 19 <b>57</b> , to <b>4/18</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4/18</b> , 19 <b>57</b> , and that death occurred at <b>9:50</b> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Center, Maryland</b> DATE SIGNED <b>THU RSTON HARRISON M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>4/21/57</b>							
22b. DATE THEREOF <b>4/21/57</b>							
22c. NAME OF CEMETERY OR CREMATORY <b>McDonnell Cemetery</b>							
22d. LOCATION (City, town, or county) (State) <b>Shallboro, Del</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Thompson</b>							
24. REC'D BY REGISTRAR <b>W. H. Neenan</b>							
24b. REGISTRAR'S SIGNATURE <b>W. H. Neenan</b>							

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		SPECIAL OCCUPATION		MILITARY SERVICE	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		DRIVER		NONE		NONE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
APR 4 1968		MEMPHIS		HEART DISEASE		SUICIDE		CORONARY ARTERY DISEASE		DIZZINESS		NONE		NONE	
TIME OF DEATH		HOURS		MINUTES		TEMPERATURE		PULSE		BLOOD PRESSURE		RESPIRATION		CONSCIOUSNESS	
11:00 AM		11		00		100.0		60		120/80		20		ALERT	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF CHURCH		SIGNATURE OF FUNERAL HOME	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. S.

APR 29 1968

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4487 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film 4214 5-3-57 et

04491

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN lb <u>11 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47X-3</u> d. STREET ADDRESS <u>1418 Crittenden N. W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First Middle Last 4. DATE OF DEATH <u>4</u> <u>18</u> <u>1957</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>August 8, 1929</u> 9. AGE (In years last birthday) <u>27</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Patent Office</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Patent Examiner</u> 11. BIRTHPLACE (State or foreign country) <u>North Carolina</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles F. Hoffer</u> 14. MOTHER'S MAIDEN NAME <u>Patricia Wood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> 16. SOCIAL SECURITY NO. <input type="checkbox"/> 17. INFORMANT <u>John I. White</u> Address <u>1105 Lamont St. Washington, D.C.</u> (cousin)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> 825X DUE TO <u>Multiple fractures of spinal column</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>And retroperitoneal hemorrhage</u> DUE TO <u>And retroperitoneal hemorrhage</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile accident</u> 20c. TIME OF INJURY Month, Day, Year <u>4-17-1957</u> Hour a. m. p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Queen Anne's County</u> 20f. (City or town) (County) (State) <u>Maryland</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . ACTUAL SIGNATURE <u>W. Henry Fisher</u> EXAMINER'S NAME (Type) <u>W. Henry Fisher</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4/18-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>april 21</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Bethesda Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac W. Love</u> ADDRESS <u>Washington D.C.</u> 24a. REC'D BY REGISTRAR <u>4/21/57</u> 24b. REGISTRAR'S SIGNATURE <u>N. H. Harris</u>	



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED  
AGE  
SEX  
DATE OF DEATH

PLACE OF DEATH  
CITY  
COUNTY  
STATE

CAUSE OF DEATH  
MANNER OF DEATH

DATE OF EXAMINATION  
TIME OF EXAMINATION

PLACE OF EXAMINATION  
CITY  
COUNTY  
STATE

NAME OF EXAMINER  
M.D.

SIGNATURE OF EXAMINER  
DATE

PLACE OF SIGNATURE  
CITY  
COUNTY  
STATE

NAME OF WITNESS  
M.D.

SIGNATURE OF WITNESS  
DATE

PLACE OF SIGNATURE  
CITY  
COUNTY  
STATE

NAME OF WITNESS  
M.D.

SIGNATURE OF WITNESS  
DATE

PLACE OF SIGNATURE  
CITY  
COUNTY  
STATE

NAME OF WITNESS  
M.D.

SIGNATURE OF WITNESS  
DATE

PLACE OF SIGNATURE  
CITY  
COUNTY  
STATE

NAME OF WITNESS  
M.D.

SIGNATURE OF WITNESS  
DATE

PLACE OF SIGNATURE  
CITY  
COUNTY  
STATE

NAME OF WITNESS  
M.D.

SIGNATURE OF WITNESS  
DATE

PLACE OF SIGNATURE  
CITY  
COUNTY  
STATE

RECEIVED  
APR 29 1957  
BUREAU V. 1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **290**

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b> c. LENGTH OF STAY IN lb <b>70 hr.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington (2)</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington (2) 47x-3</b> d. STREET ADDRESS <b>1603 Rosedale Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Lee</b> Last <b>Tackson</b>		4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 30, 1928</b>
9. AGE (In years last birthday) <b>28</b> yrs.		IF UNDER 1 YEAR Months <b>28</b> Days <b>28</b> Hours <b>28</b> Min.	IF UNDER 24 HRS. Months <b>28</b> Days <b>28</b> Hours <b>28</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Jackson</b>		14. MOTHER'S MAIDEN NAME <b>Cinderella Jackson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>15-12-34567</b>	
17. INFORMANT <b>Geraldine Jackson (wife)</b>		Address <b>1603 Rosedale Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock - Cerebral Thrombus</b> 825x DUE TO <b>Multiple Fractures -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Multiple Fractures -</b> (b) <b>Multiple Fractures -</b> (c) <b>Multiple Fractures -</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 days -</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile Accident</b>	
20c. TIME OF INJURY Month, Day, Year <b>11 a.m. 4/22/1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) <b>Rural Henderson</b> (County) <b>Caroline</b> (State) <b>N.C.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Dawson D. George</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Denton, Md</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>4/29/57</b>		22b. DATE THEREOF <b>Clifton V.A.</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lee U.A.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Ashwell</b>		ADDRESS <b>Barton, Md.</b>	
24a. REC'D BY REGISTRAR <b>4/29/57</b>		24b. REGISTRAR'S SIGNATURE <b>N.A. Nervix</b>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____ SEX _____ AGE _____ DATE OF BIRTH _____ PLACE OF BIRTH _____ OCCUPATION _____ MARITAL STATUS _____ PLACE OF DEATH _____ DATE OF DEATH _____ TIME OF DEATH _____ CAUSE OF DEATH _____ MANNER OF DEATH _____ MEDICAL HISTORY _____ PHYSICAL EXAMINATION _____ LABORATORY EXAMINATIONS _____ POSTMORTEM EXAMINATION _____ SIGNATURE OF MEDICAL EXAMINER _____ DATE _____ PLACE _____ TITLE _____ SIGNATURE OF WITNESS _____ DATE _____ PLACE _____ TITLE _____	
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BUREAU V. 5

MAY 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4506  
CERTIFICATE OF DEATH

04493

Reg. Dist. No.

291

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>TALBOT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Michaels</b>				c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x 2 St. Michaels</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MAURICE</b> Middle <b>F.</b> Last <b>CBYES</b>				4. DATE OF DEATH Month <b>April</b> Day <b>18</b> Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>UNKNOWN</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEACHER - BOOKKEEPER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>SEAFOOD</b>		11. BIRTHPLACE (State or foreign country) <b>TALBOT Cty., Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>HENRY JONES</b>			
14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>No</b>				17. INFORMANT <b>KENWORTH JONES</b> Address <b>1426 No. 15th St Phila. 21 - PA.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia - lobar - Bilateral</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cardiac failure - chronic</b> DUE TO (c) <b>2 yrs</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arteriosclerotic cardio-cerebrovascular</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1-7-53</b> , 19 <b>53</b> , to <b>4-18</b> , 19 <b>57</b> ; that I last saw the deceased alive on <b>4-18</b> , 19 <b>57</b> , and that death occurred at <b>8:00 P.M.</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>St. Michaels Md.</b>				DATE SIGNED <b>4-22-57</b>			
ACTUAL SIGNATURE <b>Norman D. Marshall</b>				M.D. <b>St. Michaels Md.</b>			
PHYSICIAN'S NAME (Type) <b>Norman D. Marshall</b>				22a. REC'D BY REGISTRAR <b>APR 23 1957</b>			
22b. DATE THEROF <b>4/22/57</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Old St. Michaels</b>		22d. LOCATION (City, town, or county) (State) <b>St. Michaels Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Norman D. Marshall</b>				ADDRESS <b>St. Michaels, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 23 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Miss R. E. Sch...</b>				24c. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1912</i>	
5. PLACE OF BIRTH <i>Washington, D.C.</i>		6. OCCUPATION <i>Engineer</i>	
7. MARITAL STATUS <i>Married</i>		8. PLACE OF DEATH <i>Home</i>	
9. CAUSE OF DEATH <i>Heart Disease</i>		10. MEDICAL HISTORY <i>None</i>	
11. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		12. SIGNATURE OF WITNESSES <i>John Doe, Jane Doe</i>	
13. DATE OF DEATH <i>Apr 23 1957</i>		14. TIME OF DEATH <i>10:00 AM</i>	
15. PLACE OF INTERMENT <i>St. Mary's Cemetery</i>		16. NAME OF FUNERAL HOME <i>None</i>	
17. SIGNATURE OF REGISTRAR <i>John Doe</i>		18. SIGNATURE OF CLERK <i>Jane Doe</i>	

RECEIVED  
APR 23 1957  
BUREAU V. S.



4507

## CERTIFICATE OF DEATH

Reg. Dist. No.

291

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wittman</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Osburt</b> Middle <b>H.</b> Last <b>Lednum</b>				4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 4, 1875</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Oyster</b>		11. BIRTHPLACE (State or foreign country) <b>Wittman, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>William H. Lednum</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ann Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>				16. SOCIAL SECURITY NO. <b>220-12-2352</b>		17. INFORMANT <b>Mrs. Osburt H. Lednum, Wittman Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>592X</b> <b>Franko-pneumonia</b> DUE TO (b) <b>Uremia</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <b>Chronic nephritis (pyelonephritis)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>7 days</b> <b>7 years</b>				INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>7 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>25 Sept</b> , 19 <b>56</b> , to <b>7 April</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>7 April</b> , 19 <b>56</b> , and that death occurred at <b>7:40 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R. Lane Wroath</b>				ADDRESS (Street, city or town, state). <b>Box 487, St. Michaels, Md.</b>			
DATE SIGNED <b>4-8-57</b>							
PHYSICIAN'S NAME (Type) <b>J. H. Moore</b>				ADDRESS <b>Tilghman, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/9/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>St. Michaels, Talbot Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. H. Moore</b>				24a. REC'D BY REGISTRAR <b>DR 10 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mr. G. H. Lednum</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4489

CERTIFICATE OF DEATH

04495  
 Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>Linnwood Louman</u>				4. DATE OF DEATH <u>April 9 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 29, 1890</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State at foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Louman</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Kemp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. William Smith (sister)</u> <u>Easton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphatic Leukemia</u> DUE TO <u>2040</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:18 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.				ADDRESS (Street, city or town, state) <u>219 S. Washington St. Easton, Md.</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				DATE SIGNED <u>Apr 9 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr 11, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newnam &amp; Son</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR <u>4/11/57</u>		24b. REGISTRAR'S SIGNATURE <u>M. E. Newnam</u>	

RECEIVED

4508

## CERTIFICATE OF DEATH

Reg. Dist. No.

291

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>TALBOT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL- ST. MICHAELS</b>				c. LENGTH OF STAY IN 1b <b>1 YR.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>BIO VISTA NURSING HOME</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>James Henry Moore</b>				4. DATE OF DEATH <b>April 15 1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 5, 1875</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OWNER-OPERATOR-RET. RESTAURANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE MOORE</b>				14. MOTHER'S MAIDEN NAME <b>HARRIET TILGHMAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. CHAS. W. MOICE</b> Address <b>EASTON, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> (c) <b>Diabetes Mellitus</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Instant.</b> <b>yes.</b> <b>yes.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.0</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/23</b> , 19 <b>56</b> to <b>4/10</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4/10/57</b> , 19 <b>57</b> , and that death occurred at <b>6:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>EASTON, Md.</b> DATE SIGNED <b>4/16/57</b>							
ACTUAL SIGNATURE <b>Shuech Jr.</b>				M.D. <b>Easton, Md.</b>			
PHYSICIAN'S NAME (Type) <b>S. Krech, Jr.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>APR. 18, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>PRESBYTERIAN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>Snow Hill, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Hampton Canoll</b>				ADDRESS <b>Easton, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 18 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Mrs. R. L. Leth</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG211, 4-20-57 et

04497

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>30 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>1 EASTON MARYLAND</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Murray</u> Last <u>Murray</u>				4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1880</u> <u>March 17 1880</u>	9. AGE (In years lost birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Charles Murray</u>				14. MOTHER'S MAIDEN NAME <u>Virginia</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ella Green (sister)</u> Address <u>Oxford, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Int. Arteriosclerosis</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>yes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>026X C.H.S. Lues.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u>a. p.</u> Month <u>  </u> Day <u>  </u> Year <u>19</u> p. m.			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-1</u> 19 <u>56</u> , to <u>4-10</u> 19 <u>57</u> , that I last saw the deceased alive on <u>4-10</u> 19 <u>57</u> , and that death occurred at <u>10:00</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. F. Buell</u>				ADDRESS (Street, city or town, state) <u>Holdsboro St, Easton, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Martin F. Buell</u>				DATE SIGNED <u>4-11-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>4/15/57</u>		<u>Oxford</u>		<u>Oxford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Weddells</u>				ADDRESS <u>Easton Md</u>		24a. REC'D BY REGISTRAR DATE <u>4-12-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>N.H. Newkirk</u>			

DEPARTMENT OF HEALTH—BAYLOR

APR 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04498

4509

## CERTIFICATE OF DEATH

Reg. Dist. No.

291

1. PLACE OF DEATH o. COUNTY <b>Talbot</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sherwood</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x 2 Sherwood</b>	
d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Teanie</b> Last <b>Palmer</b>		4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/22/1906</b>
9. AGE (In years last birthday) <b>50</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seafood Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>	
11. BIRTHPLACE (State or foreign country) <b>Talbot Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Robert Honey</b>		14. MOTHER'S MAIDEN NAME <b>Lottie Bailey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-01-8986</b>	
17. INFORMANT <b>Lawrence Palmer</b>		Address <b>Sherwood, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary occlusion</b> <b>241X</b> DUE TO <b>chronic bronchitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> (c) <b>arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b> <b>20 years</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1935</b> to <b>April 16, 1957</b> , that I last saw the deceased alive on <b>April 15, 1957</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>GUY M REESER Sr</b> M.D. <b>ALGHMAN Md</b> PHYSICIAN'S NAME (Type) <b>GUY M REESER Sr</b> <b>ALGHMAN Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/20/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sherwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Sherwood, Talbot Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Norman D. Marshall</b>		ADDRESS <b>St. Michaels, Md.</b>	
24. RECD BY REGISTRAR <b>APR 22 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mrs. R. R. Beth</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Room 306, Airport Hotel, Memphis, Tennessee	
7. CAUSE OF DEATH Suicide by gunshot		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Jackson, Mississippi	
10. DATE OF BIRTH January 19, 1933		11. PLACE OF BIRTH Jackson, Mississippi		12. OCCUPATION Attorney	
13. MARITAL STATUS Single		14. EDUCATION High School Graduate		15. RELIGION Methodist	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF WITNESSES J. Edgar Hoover, Director J. Lee Rankin, Deputy Director		18. SIGNATURE OF PHYSICIAN Dr. J. Lee Rankin	
19. SIGNATURE OF CORONER Dr. J. Lee Rankin		20. SIGNATURE OF JURY J. Edgar Hoover, Director J. Lee Rankin, Deputy Director		21. SIGNATURE OF JURY J. Edgar Hoover, Director J. Lee Rankin, Deputy Director	

RECEIVED  
APR 22 1968  
BUREAU V. S.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4491

## CERTIFICATE OF DEATH

04499

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Zastion</u>				c. LENGTH OF STAY IN 1b <u>8 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial</u>				e. STREET ADDRESS <u>15 Washington St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Nannie</u> Middle <u>R.</u> Last <u>Parrott</u>				4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 6, 1880</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Franklin M. Parrott</u>		14. MOTHER'S MAIDEN NAME <u>Margaret E. Wright</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mr. Franklin M. Parrott</u> Address <u>Trappe, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage Left</u> 331X DUE TO (b) <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>331X</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>219 S. Washington St. 7/1/57</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				M.D. <u>Eastern 16, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Apr. 23, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Zastion, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice K. Kaurman</u> ADDRESS <u>504 Eastern, Md</u>				24a. REC'D BY REGISTRAR DATE <u>4/23/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Newell</u>	

# CERTIFICATE OF DEATH

1957

<p>1. NAME OF DECEASED                  [Faint text: ...]</p>		<p>2. SEX                  [Faint text: ...]</p>	
<p>3. AGE                  [Faint text: ...]</p>		<p>4. DATE OF BIRTH                  [Faint text: ...]</p>	
<p>5. PLACE OF BIRTH                  [Faint text: ...]</p>		<p>6. OCCUPATION                  [Faint text: ...]</p>	
<p>7. MARITAL STATUS                  [Faint text: ...]</p>		<p>8. CAUSE OF DEATH                  [Faint text: ...]</p>	
<p>9. PLACE OF DEATH                  [Faint text: ...]</p>		<p>10. DATE OF DEATH                  [Faint text: ...]</p>	
<p>11. SIGNATURE OF DECEASED                  [Faint text: ...]</p>		<p>12. SIGNATURE OF WITNESS                  [Faint text: ...]</p>	
<p>13. SIGNATURE OF PHYSICIAN                  [Faint text: ...]</p>		<p>14. SIGNATURE OF CORONER                  [Faint text: ...]</p>	

BUREAU V. S.

APR 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for use in burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04500

4492

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>5 hrs 45 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>J</u> Last <u>Pearson</u>				4. DATE OF DEATH Month <u>4</u> - Day <u>5</u> - Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 18, 1909</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pet Milk Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Isaac Pearson</u>			
14. MOTHER'S MAIDEN NAME <u>Maggie McHatt</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>213-01-7090</u>			
16. SOCIAL SECURITY NO. <u>213-01-7090</u>				17. INFORMANT <u>Mrs. Ella A. Pearson (wife)</u> Address <u>Greensboro, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			(County)		(State)		
21. I certify that I attended the deceased from <u>4/4</u> , 19 <u>57</u> , to <u>4/5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/5/57</u> , and that death occurred at <u>2:15</u> A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thorston Harrison</u> M.D. <u>Caroline, Maryland</u> DATE SIGNED _____							
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/8/57</u>		<u>Greensboro</u>		<u>Greensboro Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulan</u>				ADDRESS <u>Greensboro, Md.</u>		24a. RECEIVED BY REGISTRAR DATE <u>7/8/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>N. H. Newlin</u>			

APR 23 1957

**BUREAU V. S.**

RECEIVED

# STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 10a, block 22 Film G211 4-29-57 et

04501

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>30 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) First <i>Myrl</i> Middle <i>Price</i> Last <i>Price</i>		4. DATE OF DEATH Month <i>April</i> Day <i>15</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 5, 1890</i>
9. AGE (In years lost birthday) <i>66</i> yrs.		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Iron Worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Gas &amp; Electric Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas Richard Price</i>		14. MOTHER'S MAIDEN NAME <i>Susie Kirby</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-05-4573</i>	
17. INFORMANT Address <i>Mrs. Edith Price - wife</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebral Hemorrhage</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arteriosclerotic cerebro-vascular</i> DUE TO (c) <i>Hypertension, Essential Vas.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4-10</i> , 19 <i>57</i> , to <i>4-15</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>4-15</i> , 19 <i>57</i> , and that death occurred at <i>10:25</i> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Guy M. Reeser</i> M.D.		ADDRESS (Street, city or town, state) <i>St Michaels</i>	
PHYSICIAN'S NAME (Type) <i>Guy M. Reeser</i> M.D.		DATE <i>4-16-57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4-19-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Mem. Grave</i>	22d. LOCATION (City, town, or county) (State) <i>Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>George L. Schwab</i>		ADDRESS <i>2101 Frederick</i>	24. REC'D BY REGISTRAR <i>4/16/57</i>
25. A15 (4) 15M 9/55		26. REGISTRAR'S SIGNATURE <i>N.H. Neer</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for no burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore 19

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		MANNER OF DEATH	
EDUCATION		OCCUPATION	
BIRTH DATE		BIRTH PLACE	
MARRIAGE		PREVIOUS MARRIAGES	
CAUSE OF DEATH		IMMEDIATE CAUSE	
DISEASE		SYMPTOMS	
TREATMENT		HISTORY	
FAMILY HISTORY		SOCIAL HISTORY	
AUTOPSY		LABORATORY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		PLACE	

BUREAU V. 3

Apr 29 1957

RECEIVED

4510

## CERTIFICATE OF DEATH

04502

Reg. Dist. No.

290

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BURAL - TRAPPE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BURAL - TRAPPE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LEOYD'S LANDING ROAD</u>				d. STREET ADDRESS <u>LEOYD'S LANDING ROAD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES HENRY GIBSON SAULSBURY</u>				4. DATE OF DEATH Month Day Year <u>APRIL 18 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 3, 1893</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AGRICULTURE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>RICHARD W. SAULSBURY</u>				14. MOTHER'S MAIDEN NAME <u>LAURA LYONS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-36-1153</u>		17. INFORMANT <u>Mrs. INDIA B. SAULSBURY, TRAPPE R.D. MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, acute</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>6 mos.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Hours.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT. 11, 1956</u> to <u>APR. 18, 1957</u> , that I last saw the deceased alive on <u>APR. 18, 1957</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>EASTON MARYLAND</u> DATE SIGNED <u>4/23/57</u>							
ACTUAL SIGNATURE <u>Shepard Krech Jr.</u> M.D.				PHYSICIAN'S NAME (Type) <u>Shepard Krech Jr</u> <u>Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APR. 22, '57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>EASTON MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hampton Conwell</u> ADDRESS <u>EASTON, MD.</u>				24a. REC'D BY REGISTRAR <u>MAY 1 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. M. H. Reming</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1957-001-100

NAME OF DECEASED <i>WILLIAM J. BROWN</i>		DATE OF DEATH <i>1957-05-01</i>	
PLACE OF DEATH <i>Home</i>		CITY AND COUNTY <i>Baltimore, Maryland</i>	
AGE <i>78</i>		SEX <i>Male</i>	
RACE <i>White</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>Retired</i>		MARRIAGE <i>Married</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>	
DATE OF SIGNATURE <i>1957-05-02</i>		DATE OF SIGNATURE <i>1957-05-02</i>	

BUREAU V. S.

MAY 1 1957

RECEIVED

4494

CERTIFICATE OF DEATH

04503

Reg. Dist. No.

790

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Sherwood</u> Last <u></u>		4. DATE OF DEATH Month <u>4</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-25-88</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u></u>	17. INFORMANT <u>Charles James Easton, md.</u> Address
-----------------------------------------------------------------------------------------------------------	------------------------------------	-----------------------------------------------------------

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>My peritonitis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>5-6 days</u> <u>2-3 years</u>
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	-------------------------------------------------------------------------

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>Feb 23</u> , 19 <u>57</u> , to <u>4/15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/15</u> , 19 <u>57</u> , and that death occurred on <u>4/15</u> , 19 <u>57</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Daynard J. Hill</u> M.D.	ADDRESS (Street, city or town, state) DATE SIGNED
PHYSICIAN'S NAME (Type)	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>4/19/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Richards</u>	22d. LOCATION (City, town, or county) (State) <u>EASTON, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Doshell</u> ADDRESS <u>Easton md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 29 1957</u>	24b. REGISTRAR'S SIGNATURE <u>N. A. Rerring</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with various fields for death certificate, including name, date, and cause of death. The form is mostly blank with some faint markings.

*Handwritten notes:*  
Government of Maryland  
3-2-58  
3-2-58

*Handwritten notes:*  
4/10/58  
4/10/58  
4/10/58

BUREAU V. 3

APR 29 1957

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										04504
4495 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 290
1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>TALBOT</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>			c. LENGTH OF STAY IN lb <u>DOH</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 ROYAL OAK</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MEMORIAL HOSP.</u>					d. STREET ADDRESS <u>1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARROLL LEE SIMMONS</u>					4. DATE OF DEATH Month Day Year <u>APR 8 19 57</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT 13-37</u>		9. AGE (In years last birthday) <u>19</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SERVICEMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ARMY</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Deceased - WILLIAM W.</u>				14. MOTHER'S MAIDEN NAME <u>LUCY C. SLACUM</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES. Active service</u>				16. SOCIAL SECURITY NO. <u>1</u>		17. INFORMANT <u>BARBARA TARMON-SISTER</u> Address <u>910 S. AURORA ST. EASTON.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>into a car - Broken neck - fracture</u> 825x DUE TO (b) <u>right arm + right leg</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Speed and he ran off State highway</u>						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>Apr 8 1957</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>State highway + near Wye Mills</u>		20f. (City or town) (County) (State) <u>MD.</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>W D Henry Fisher</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <u>4/8-57</u>
EXAMINER'S NAME (Type) _____					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>4/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>St. Michaels Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. Lamberton</u>					ADDRESS <u>St. Michaels Md</u>		24a. REC'D BY REGISTRAR <u>N. H. Newlin</u>		24b. REGISTRAR'S SIGNATURE <u>DATE 4/11/57</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH-BALLBORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

BUREAU V. 8

APR 15 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4511

## CERTIFICATE OF DEATH

04505

Reg. Dist. No.

299

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. MICHAELS</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARA JENNESS SPENCER</u>				4. DATE OF DEATH Month Day Year <u>April 12 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 7, 1893</u>	
9. AGE (In years, last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>10</u>		IF UNDER 24 HRS. Months Days Hours Min. <u>10</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MUSIC TEACHER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MUSIC</u>		11. BIRTHPLACE (State or foreign country) <u>CLINTON, MASS.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>DR. JOHN WADE</u>				14. MOTHER'S MAIDEN NAME <u>KATIE WOOD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. RUSSELL Smith, R.R. EASTON, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic coronary heart d.</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive cardiovascular d.</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11-22-</u> 19 <u>52</u> , to <u>4-12-</u> 19 <u>57</u> , that I last saw the deceased alive on <u>4-12-</u> 19 <u>57</u> , and that death occurred at <u>11:30</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thym Reese Jr</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>St. Michaels Md. 4-13-57</u>			
PHYSICIAN'S NAME (Type) <u>Thym Reese Jr</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>April 15, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OLIVET CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>St. MICHAELS MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman D. Marshall</u>				ADDRESS <u>St. MICHAELS, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 18 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mr. J. H. [Signature]</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item 8 Film 6214 4-10-57 et

04506

4496

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marydel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>0502</u>	
3. NAME OF DECEASED (Type or print) First <u>Dora</u> Middle <u>B.</u> Last <u>Stafford</u>		4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19-1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>W</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr. J. Walls</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Wallace Stafford (son)</u>		Address <u>Marydel, Del</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u> DUE TO (c) <u>Advanced atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>11:10 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.		ADDRESS (Street, city or town, state) <u>219 S. Washington St. Md.</u> DATE SIGNED <u>4/9/57</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		<u>Easton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/9/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Templeville</u>	22d. LOCATION (City, town, or county) (State) <u>Templeville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulais</u> ADDRESS <u>Greensboro, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>4/9/57</u> 24b. REGISTRAR'S SIGNATURE <u>N. H. Newis</u>	



APR 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04507

4497

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Thomas</u> Last <u>Thomas</u>				4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-16-1867</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Anna Elizabeth Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Mrs. Nettie Thomas</u> Address <u>Luxettman Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uremia</u> DUE TO (c) <u>Hypertensive Cerebrovascular Cardiovascular Dis - 50 years</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(b) (c)</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>November 1956</u> to <u>April 1957</u> , that I last saw the deceased alive on <u>April 1957</u> , and that death occurred at <u>10:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. Henderson</u> M.D.				ADDRESS (Street, city or town, state) <u>Box 487, St. Michaels, Md.</u> DATE SIGNED <u>4-8-57</u>			
PHYSICIAN'S NAME (Type) <u>R. Henderson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 11, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Michaels, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Michaels Harrison</u> ADDRESS <u>St. Michaels, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 4/11/57</u>		24b. REGISTRAR'S SIGNATURE <u>N.H. Harris</u>	

BUREAU V. S.

APR 15 1957

RECEIVED

4512

## CERTIFICATE OF DEATH

Reg. Dist. No.

291

1. PLACE OF DEATH a. COUNTY <u>talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Royal oak</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Royal Oak</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Box 145</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>L. Wallace</u> Last <u>Wallace</u>		4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cal</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/31/68</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Wallace</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Sherwood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic C.V.D.</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-13</u> , 19 <u>56</u> , to <u>4-13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-13</u> , 19 <u>57</u> , and that death occurred at <u>4:25</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Reeser Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>St Michaels Md</u>	
PHYSICIAN'S NAME (Type) <u>James M. Reeser Jr.</u>		DATE SIGNED <u>4-16-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/18/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Royal oak Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Royal oak Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Corbitt, Easton, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 22 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Mrs. R. R. Reeser</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
William Koller		Male		60		1897		Germany	
Usual Residence		Occupation		Cause of Death		Date of Death		Place of Death	
1000 E. 1st St.		Retired		Heart Disease		April 13, 1957		Baltimore, Md.	
Physician		Medical Examiner		Hospital		Burial Place		Date of Burial	
J. Koller		J. Koller		St. Mary's Hospital		St. Mary's Cemetery		April 15, 1957	

BUREAU V. 2

APR 22 1957

RECEIVED



1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>1 hr. 10 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>500 Talbot St.</u>			
3. NAME OF DECEASED (Type or print) <u>Trusty</u> First Middle Last				4. DATE OF DEATH <u>April</u> Month Day Year <u>22</u> <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 1880?</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Unknown Wells</u>				14. MOTHER'S MAIDEN NAME <u>Victoria Ridout</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Joseph Wells (son) Wittman, Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>cerebral arteriosclerosis</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive cardio-vascular</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4-22-1957</u> to <u>4-22-1957</u> , that I last saw the deceased alive on <u>4-22-1957</u> , and that death occurred at <u>11:55</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph M. Reeser</u> M.D.				DATE SIGNED <u>4-22-57</u>			
PHYSICIAN'S NAME (Type) <u>Joseph M. Reeser</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New St. Michaels Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Michaels, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman W. Marshall</u> ADDRESS				24a. RECEIVED BY REGISTRAR DATE <u>4/25/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Newlin</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4513

CERTIFICATE OF DEATH

Reg. Dist. No.

04510

290

1. PLACE OF DEATH o. COUNTY <b>Talbot</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxford</b>				c. LENGTH OF STAY IN 1b <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pleasant St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>OSCAR MONNIE WHITE</b>				4. DATE OF DEATH Month <b>April</b> , Day <b>1</b> , Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 24, 1884</b>	9. AGE (In years last birthday) yrs. <b>72</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		
13. FATHER'S NAME <b>Oscar D. White</b>			14. MOTHER'S MAIDEN NAME <b>Mary Anna Cullison</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-16-9296</b>		17. INFORMANT <b>Mrs. Ethel White</b>			
				Address <b>Oxford, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>none</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>11:30 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Norman Tarr, M.D.</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. Norman Tarr</b> <b>Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 4, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oxford Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Oxford, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newnam &amp; Son</b>			ADDRESS <b>Easton, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>4/4/57</b>	24b. REGISTRAR'S SIGNATURE <b>N.A. Newnam</b>	

CERTIFICATE OF DEATH

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BUREAU V. B.

APR 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4493

CERTIFICATE OF DEATH

04511

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely 05x02</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>S. WASHINGTON, St.</u>			
3. NAME OF DECEASED (Type or print) <u>First Sarah Middle Jane Last Wyatt</u>				4. DATE OF DEATH <u>April 21 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13 1868</u>	9. AGE (In years lost to day) <u>89</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Andrew Gibbs</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				17. INFORMANT <u>Walter Gibbs</u> Address <u>Ridgely, Md.</u>			
16. SOCIAL SECURITY NO.				14. MOTHER'S MAIDEN NAME <u>Maria Henry</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO (b) <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Lobular pneumonia</u> DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>219 S. Washington St. Easton 16, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>				DATE SIGNED <u>21 Apr 57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4/24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shenton</u>		22d. LOCATION (City, town, or county) (State) <u>Shenton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.E. Boulais Greensboro, Md</u>				24a. REC'D BY REGISTRAR <u>DATE 4/24/57</u>		24b. REGISTRAR'S SIGNATURE <u>N.H. Neerix</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 13

BUREAU V. S.

APR 29 1957

RECEIVED

1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**4500**

**CERTIFICATE OF DEATH**

04512

Reg. Dist. No. **290**

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Easton Memorial Hosp.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS <b>1 Dover St.</b>							
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>W.</b> Last <b>ZABARA</b>				4. DATE OF DEATH Month <b>4</b> Day <b>4</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 1898</b>	
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Russia</b>				12. CITIZEN OF WHAT COUNTRY? <b>Russell U.S.A.</b>			
13. FATHER'S NAME <b>Jacob Zabara</b>				14. MOTHER'S MAIDEN NAME <b>Enta Icaroff</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
17. INFORMANT <b>Mrs Maria Zabara, wife - same</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastrointestinal Hemorrhage</b> <b>155x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of gall bladder</b> DUE TO (c) <b>2 mos.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1 March 1957</b> to <b>4/3 1957</b> , that I last saw the deceased alive on <b>4/3 1957</b> , and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Shuecu, Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>Easton</b> DATE SIGNED <b>4/4/57</b>			
PHYSICIAN'S NAME (Type)							
22a. BYRIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>Apr. 6, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Sharon Cemetery, Philadelphia, Pa.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Marvin E. Newman</b> ADDRESS <b>1501 Easton, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>4/6/57</b> 24b. REGISTRAR'S SIGNATURE <b>N. H. Newman</b>			

